STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155656	A. BUILDING 00 B. WING	09/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY NURSING AND REHABILITATION CENTER	2827 NORTHGATE BLVD FORT WAYNE, IN46835

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F0000	This visit was for the Investigation of Complaint IN00096881. This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00095525. Complaint IN00096881- Substantiated. Federal/State deficiencies related to the allegations are cited at F226. Survey dates: September 27 & 28, 2011 Facility number: 000275 Provider number: 155656 AIM number: 100290930 Survey team: Rick Blain, RN TC Census bed type: SNF/NF: 111 Residential: 13 Total: 124 Census payor type: Medicare: 12 Medicaid: 86 Other: 26 Total: 124 Sample: 4	F0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conculsions set forth in the statement of deficiencies. This plan of correction is prepared soley because it is required by the provision of federal and state law. We respectifully request this plan of correction serve as our allegation of compliance effective 10-1-11	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	Canterbury Nursing and Rehabilitation Center was found to be in substantial compliance with 42 CFR Part 483, Subpart B in regard to the Investigation of Complaint IN00096881. This deficiency reflects a state finding cited in accordance with 410 IAC 16.2. Quality review completed on September 29, 2011 by Bev Faulkner, RN			
F0226 SS=A	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure a licensed nurse immediately reported an incident of a resident to resident altercation to the Administrator as required by facility policy after being informed of the altercation by a CNA. This altercation involved Residents # C and # E in the sample of 4. Findings include:	F0226	It is the policy of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (1) Corrective Action taken for alleged deficient practice: The nurse involved was suspended per the facility abuse protocol and a through investigation was completed. The nurse was utimately terminated for failure to follow the facility policy regarding the reporting of res to res altercations and/or	10/01/2011

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	The facility Administrator was interviewed on 9/28/11 at 10:00 A.M. During the interview, the Administrator indicated there had been an incident on 9/27/11 at 2:00 P.M., involving an alleged altercation between two residents (Resident #E and Resident #C). The Administrator indicated a CNA had observed Residents #C and #E on 9/27/11 at 2:00 P.M., sitting next to each other in their wheel chairs near the nursing desk. The CNA observed Resident #E kick Resident #C on the left elbow. The CNA checked Resident #C for injury and then informed a nurse who was working at the nursing desk that Resident #E had just kicked Resident #C on the elbow. The nurse looked up from her work and instructed the two residents to move away from each other and then went back to her work. The CNA realized the nurse was not going to take further action and so the CNA informed her supervisor and the two of them then informed the Administrator of the incident. The Administrator further indicated the nurse had been suspended pending investigation of the incident and would be facing disciplinary action for failing to immediately report the incident immediately to the Administrator according to the facility policy on abuse. The Administrator further indicated Resident #E had no history of prior incidents.		abuse. Res C & Res E were assessed and were found to have no injuries and utimately found to be teasing each other. The physician and family of both residents were notified of the incident. (2) Identification of other residents that have potential to be affected by the alleged deficient practice: All residents can be affected. The nurses were quized regarding the policy and all were aware that the administrator is to be notified immediately regarding any alleged abuse or resident to resident altercations. (3) Systematic changes to ensure alleged practice does not recur: Staff were re-inserviced regarding the facility's policy and procedure regarding reporting guidelines and abuse protocol. These policies will be reviewed as part of the agenda during monthly all-staff meetings by the Director of Education and/or Administrator. (4) How system will be monitored to ensure that alleged deficient practice does not recur: The Director of Education will quiz staff randomly to establish their knowlege base of the facility's abuse protocol and procedures. The results will be recorded on a CQI tool that the administrator will review once a week for 4 wks to determine if there are additional training needs. The CQI tool will be included in the CQI meeting monthly for 3 months to ensure that all staff are aware of the	

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	CNA #2 was interviewed on 9/28/11 at 11:55 A.M. During the interview, CNA #2 indicated that on 9/27/11 at 2:00 P.M. she had observed Residents #E and #C sitting next to each other in their wheel chairs near the main nursing desk. She observed Resident #E look around and then kick Resident #C on the left elbow. She checked Resident #C for injury and then informed the nurse at the nursing desk that Resident #E had just kicked Resident #C on the elbow. CNA #2 further indicated the nurse looked up from her work and told the two residents to move apart from each other and then went back to her work. CNA #2 indicated that when she realized the nurse was not going to take any further action, she immediately informed her supervisor and they went to the Administrator to inform them of the incident. The record for Resident #C was reviewed on 9/27/11 at 11:30 A.M. Diagnoses included, but were not limited to, multiple sclerosis. The record for Resident #C was reviewed again on 9/28/11 and indicated the resident had been assessed for injury following the incident and there were no injuries noted. The record further indicated the resident's family and		reporting guidelines and will be discontinued when all checks indiciate 100% compliance.	

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	physician had been notified of the incident. The record for Resident #E was reviewed on 9/28/11 at 12:15 P.M. Diagnoses included, but were not limited to, stroke and aphasia (difficulty speaking). The record of Resident #E indicated the resident had been assessed for injury following the incident and there were no injuries noted The record further indicated orders had been received to obtain a urinalysis and obtain a psychiatric evaluation. The record indicated the resident had been placed on fifteen minute monitoring and the care plan had been updated. A facility policy on abuse, with a revision date of July 2010, indicated allegations of abuse were to be reported immediately to the Administrator. This federal tag relates to Complaint IN00096881. 3.1-28(a)			